AMA Queensland Feedback

Queensland Health Networked Services Framework

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AMA Queensland thanks Queensland Health for the opportunity to provide feedback on its draft Networked Services Framework (the 'Framework'). We also thank Queensland Health staff for providing an associated briefing on 6 December 2023.

Set out below for the Department's consideration are comments and feedback provided by AMA Queensland members on:

- the Framework's broad application;
- clinician experiences of such models; and
- general comments regarding the material provided by Queensland Health.

Please note that some of the feedback relates to first-hand clinician experience of the complexities of regional and rural practice across often siloed or, at best, poorly connected HHSs and systems and would benefit from greater enunciation by the particular specialists involved. AMA Queensland has confirmed with these doctors that they are willing to meet with Queensland Health representatives to explain these complex issues further should the Department so desire.

Comments regarding broad Framework application

The Framework is recognised as having both a high-level purpose to guide the establishment of sustainable networked services and local-level application so particular HHSs can tailor operations to suit their specific needs. AMA Queensland acknowledges that Queensland Health has developed the Framework in response to the ad-hoc evolution of location-specific networked models that were heavily dependent on the dedication and enthusiasm of, and interpersonal relationships amongst, individual clinicians but often deficient in sustainable governance and funding structures. These informal and practitioner/personality-dependent arrangements left such services vulnerable to sudden closure when key staff resigned or otherwise became unavailable or financial arrangements amongst HHSs ceased.

In addition, AMA Queensland members advise that regional, rural and remote patients are suffering acute and emergency issues as a result of the absence of timely outpatient or elective procedures. Worse still, doctors are reporting that patients are often receiving no diagnosis or treatment at all due to the lack of an appropriate specialist. Compounding these issues are the subsequent inefficiencies caused within regional

health services, including double-handling, misdirected care and delays due to a lack of timely direction from distant sites. Put simply, AMA Queensland and our members recognise the urgent need for immediate restoration of at least a base-standard of specialist service provision.

That said, it is AMA Queensland's view that the Framework should not be used or perceived as a strategic solution to the crisis facing our regional, rural and remote health services but a practical tool for relevant HHSs when suitable and deemed necessary. Queenslanders deserve fully functioning health services close to where they live, and the long-term survival of our non-metropolitan health services requires significant and sustained investment in our workforce by all levels of government beyond the next election cycle. Our hard-working doctors, nurses and other staff also deserve to work in fully functioning services that enable them to maintain and grow their skills and experience career satisfaction.

Clinician experience and feedback

Feedback from AMA Queensland members on the Framework has been mixed. As stated, many doctors recognise the need for networked services in the short and medium term but report that their lived experience of such models has been negative in the main, particularly in the fields of anaesthetics and obstetrics and gynaecology (O&G).

In O&G, specialists report that networked models have had perverse outcomes by causing the loss of highly valued, regionally based clinicians to metropolitan areas, especially Brisbane. Such staff are enticed to so-called 'regional support' positions in tertiary hospitals (usually by more lucrative and favourable employment conditions) whereby they are required to move to the city and then travel back to the regions to provide specialist support.

Doctors advise, however, that these clinicians rarely travel back to the regions, sometimes for periods of nearly a whole year, leaving the regional service without a permanent O&G specialist or a city-based fly-in support. The model also results in considerable inequity between similarly qualified specialists and discontent amongst those who remain in regional areas since they are not provided the same incentives to stay in their communities.

Doctors also report that these models, particularly associated standards and care pathways, are often designed and implemented out of tertiary centres but are completely unsuited to the reality of regional health services. O&G specialists provided the following examples where such models are proving to be unworkable:

- A telehealth service has been established between a tertiary hospital and regional obstetric medicine team to provide care for pregnant women with diabetes/GDM. The relevant pathway requires blood tests and regular ultrasound scans. The regional service must adhere to these requirements despite the fact:
    - the blood tests will not change practice and are not yet considered mainstream;
    - the regional health service has a significant pathology backlog; and
    - local imaging services are stretched beyond capacity and cannot produce scans of the same quality as metropolitan tertiary services in any event.

  Doctors report that this renders these compulsory tests and scans mostly useless for the patients and causes avoidable delays in patients' treatment.

- Regional patients with gynaecological cancers are, by default, referred to a major tertiary hospital. Once again, doctors advise that completely unsuitable care pathways are mandated for the regional health service causing unacceptable treatment delays.

  Doctors report that the tertiary hospital mandates the regional service to provide multiple biopsies, all of which require surgical procedures, before it will accept patient cases for discussion. This requirement must be met despite the fact it is extremely difficult for the regional service to obtain the specimens in the first place and the existence of lengthy delays because of pathology backlogs.

  Specialists are so distressed by the delays caused to patients' treatment that they have considered performing the necessary surgeries themselves even though it would not adhere to best practice standards. Doctors rightly point out, however, that it is also arguably not best practice for patients to experience such lengthy delays for treatment of gynaecological cancers.

- Queensland Health implementation of networked models have resulted in centralisation by another name, directly causing the closure of previously functioning regional services.

  One example given was a Queensland Health decision to close a regional histology service following the resignation of a key staff member. Instead of recruiting a replacement, Queensland Health advised the local, remaining staff to relocate and take up requisite positions in Brisbane. The affected clinicians and their families had resided in the regional location for some time so were not in a position to relocate and instead resigned or retired early, leaving the local community without this valuable, local health service.

In addition to these O&G concerns, other specialists expressed frustration and distress at increasing numbers of adverse patient outcomes due to the absence of regionally based subspecialty care. The dot points below summarise some of the key issues these doctors have raised.

- Doctors were particularly frustrated that subspecialist services were not provided in regional areas despite there being sufficient demand to sustain such service provision. There was a desire for greater Queensland Health consideration of funding services on a catchment per capita basis and relative remoteness, especially for life- and organ-threatening emergency services. AMA Queensland notes we have raised the need for data analysis by patient postcode with Queensland Health and the Chief Medical Officer has advised this work is being undertaken by the Department.

- Clinicians expressed serious concerns about high workloads, including on-call and afterhours, experienced by regional practitioners in comparison to their city-based colleagues. Doctors believed that current arrangements were a key contributor to this situation, particularly the lack of alignment of networks within referral pathways for regional centres that service remote locations.

  Regional specialists advised that surgical complications arising from fly-in/fly-out networked models between rural/remote and metropolitan HHSs usually flow to a regional referral centre, directly increasing the workload of the regional clinicians, especially afterhours work. Clinicians were of the view that these impacts have a significant detrimental impact on regional clinicians but are poorly understood by Queensland Health. The doctors consulted stressed that the regional workforce must receive support for any networked solution to function, with the primary focus on distributing after-hours and emergency workload across senior medical staff statewide. Current models were viewed as mostly occurring in-hours and for elective care only.

- Whilst specialists were supportive of VMO models for contracting senior medical staff, especially in subspecialty surgical areas, they advised that Queensland Health's VMO contracts are inadequate to attract doctors. They also advocated for a hybrid model that uses local staff specialists and VMOs, with some rotating through several locations including metropolitan and private practice.

- Specialists viewed the current model, in which additional staff are employed in 'regional support' positions in metropolitan hospitals to notionally service regional areas as flawed since it:

    - created perceptions amongst doctors of a two-tiered workforce in which metropolitan specialists were regarded as more skilled and 'important' than those based in regional, rural or remote areas;

    - resulted in regional funding shifting to comparatively well-resourced metropolitan centres at the expense of regional services;

    - was inefficient as it required 4-5 city-based doctors to replace a single regional specialist;

    - had done little to reduce the out-of-hours workload with views that metropolitan centres perversely benefit from the associated on-call reductions; and

    - caused flow-on impacts for on-call rosters with regional specialists shouldering a proportionally larger burden of on-call hours as a result and significantly more on-call hours in comparison to their metropolitan-based colleagues.

  Doctors advocated for the structure to be reversed, with the focus on increasing the number of specialists in regional areas and then rotating those doctors into major tertiary hospitals to maintain skills, rather than rotating city-based doctors out to regional areas.

General comments

- AMA Queensland is pleased to see some contemplation within the Framework materials of the need for linkages with general practice. We know that our population is aging and suffering from increasing rates of chronic disease and this is being disproportionately experienced by our regional, rural and remote communities, especially First Nations Queenslanders.

  Preventative health must be a core focus of public health investment and general practice is the linchpin. Primary-tertiary collaboration and integration is also vital to ensure continuity of care and reduce pressure on our public hospitals. AMA Queensland submits that this should be given greater emphasis in the final Framework materials and refers Queensland Health to our 2023-24 pre-Budget submission which calls for a dedicated 0.5 FTE GP liaison role within the senior executive level of Queensland Health.

- It is noted that the Framework provides estimated savings to both patients and the Patient Travel Subsidy Scheme from networked service case examples. AMA Queensland members advised that they believed these figures underestimate the real costs to patients of travelling to major cities for procedures, including transport, accommodation, food, lost wages and other incidental costs. Whilst this year's Queensland Budget provided additional funding for the scheme, doctors report that it is still completely inadequate for most patients and significantly behind that provided in New South Wales.

Doctors also continue to report that the scheme is unnecessarily cumbersome and some patients are simply unable to access it at all. AMA Queensland submits that this feedback be considered for revision in the final Framework materials.

- Page 19 of the Framework states 'Allocated time for professional development needs to be balanced with service continuity and associated clinical caseloads'. It is essential for the survival of our regional, rural and remote health services that their workforces are supported to undertake training and professional development. Without it, these vital services will continue to lose often irreplaceable staff to major cities.

  AMA Queensland submits that the Framework must include the need for resourcing of regional, remote and rural services to back-fill staff whilst undertaking professional development and other training.

- Clinicians expressed concern that whilst the Framework identifies the need to incentivise regional specialist practice, it does not outline dedicated incentives for regional specialists themselves or specifically mention them in key sections of the document. This was perceived as an indication that Queensland Health does not intend to incentivise regional doctors to come and stay in our regional, rural and remote locations. Again, doctors emphasised the need to rotate regional doctors through metropolitan tertiary services to maintain and grow their skills and noted that this would be warmly welcomed by the regional workforce, along with the provision of broader professional development opportunities.

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